Current Provider Policy Information for the Home and Community Based (HCB) Waiver

Updated: (8/21/18)

- **HCB Waiver Renewal**
  - In September 2016, the Centers for Medicare and Medicaid Services (CMS) approved the renewal of the HCB waiver. Along with the renewal, new HCB waiver regulations (907 KAR 7:010 and 907 KAR 7:015) became effective. If you have any questions, please contact DMS at 502-564-5560.
- **Transition of Therapies**
  - In September 2016, Medicaid transitioned physical therapy, occupational therapy, and speech-language pathology services from the HCB waiver to state plan. This change only applies to participants in the HCB waiver. For more information, see attachment A of this document.
  - Provider Forms
    - Kentucky Medicaid Therapy Prior Authorization Request Form
    - Therapy Prior Authorization Form Instructions
    - Therapy Services Update
    - Therapy Extension Transition Spreadsheet
    - Therapy Extension Transition Spreadsheet Example
  - If you have questions about prior authorizations or billing, please email HPE.
  - If you have questions about the Medicaid state plan therapy benefit, please contact the DMS Division of Policy and Operations by email or by phone at 502-564-6890.

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Attachment A

Kentucky Medicaid Fee for Service Therapy Changes Effective September 2016

• Home and Community Based Waiver is the only waiver program transitioning individuals to state plan therapy services at this time. All other waivers can continue providing the service to the individual as a waiver service until further notice.

• Requests for therapy services to be provided by an Independent Physical, Speech or Occupational Therapist or the new Multi-Therapy Agency provider group will be reviewed by HPE.

• Requests can be submitted via fax 877-455-1275 or via email at TherapyPA_Request@hpe.com

• Authorizations will be granted for up to ninety (90) days based on the needs of the individual

• Continued authorizations may be requested up to thirty (30) days prior to the end of the individual's current prior authorization. Example: Current PA ends on 12/31/16, the reauthorization can be requested on 12/1/16.

• Once an order for therapy is written, the prior authorization must be requested within thirty (30) days of the date on the MD/ARNP/PA order.

• Authorizations will be issued for a number of visits for the authorization period rather than for a specific number of units per code. The specific code will still be required on the claim, but because the prior authorization will be granted for a number of visits it allows the provider to determine with each visit which modality/ies to provide that visit without having to submit a modification for increased units or additional codes.

• Prior Authorization Number will be required on the claim

• Example - Current day authorization
- 95860 10 units 7/1/16-7/31/16
- 95867 4 units 7/1/16-7/31/16
- 97110 6 units 7/1/16-7/31/16

• Example – Authorization beginning September 2016
- Physical Therapy 20 visits 9/15/16-12/15/16

• Changes for existing authorizations that span the September 9 date
- Existing authorizations will be end dated September 8, 2016

Provider Types 79,87,88 (Independent ST, PT, OT) will need to complete the therapy extension spreadsheet translating the number of units per code into the total number of visits per month. New orders or documentation **will not** be required, HPE will generate new authorizations for the total number of visits for the next two review periods. Beginning with the third PA request, the provider will be required to submit a new PA request with all applicable documentation.

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• Waiver Providers with new provider numbers will need to identify the individuals they will continue to serve and specify their new provider number on the therapy extension spreadsheet. Prior Authorizations will be granted for the number of visits the individual is currently authorized to receive. Beginning with the third PA request, the provider will be required to submit a new PA request with all applicable supporting documentation.

• Providers can begin submitting the spreadsheets at any time, however, the new authorizations will not be issued until September.

• During the transition period, prior authorization changes will be reviewed and issued retroactively to ensure no gaps in coverage.

Requests for new authorizations should be submitted using the new fax request form and include all applicable documentation.